DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/22/14

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview the facility failed to provide one resident (#84) an environment free of restraints of 31 residents reviewed. The findings included: Resident #84 was admitted on April 30, 2013, with diagnoses including Cardio-Vascular Disease with Pacemaker, Hypertension, and Spondylosis. Observation and Interview with the resident on January 6, 2013, at 4:00 p.m., in the resident's room, revealed the resident's bed had elevated sides to the mattress, commonly called a scoop mattress. Interview continued and the resident stated the scoop mattress "makes it hard to get out of the bed." Continued interview revealed the resident independently transferred self to the wheelchair (w/c) and into the bathroom at intervals without calling for assistance. Review of the Minimum Data Set (MDS) dated October 18, 2013, revealed the resident had no short or long term memory problems and a high BIMS score (used to measure cognitive abilities)	F 221 F221	Life Care Center of Jefferson City is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this plan is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted January 6—8, 2014. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements. **F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** To address the situation involving the facility's failure to provide resident # 84 an environment free of restraints, the resident was assessed by the charge nurse on 1/8/2014. Resident #84 and family were involved in the assessment process. Concave mattress was discontinued for resident #84.	2/22/14 2/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer B Henderson, ED.		1/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 of 14 out of a possible 15. Review of the plan of care dated October 23, 2013, revealed an approach under the Activities of Daily Living, "Capitalize on the resident's strengths and maximize independence." Review of the complete plan of care revealed the use of the scoop mattress was not included. Review of the facility's policy Physical Restraint Use revealed, "...facility...maintains an environment that fosters minimal use of restraints...The need...for restraint use is assessed on admission, at regularly scheduled interdisciplinary care plan conference reviews...A physician's order is required to apply any type of restraint." Interview with licensed practical nurse (LPN) #4 on January 7, 2014, in the conference room, at 3:10 p.m., with concurrent review of the Physical Restraint Use policy confirmed none of the five listed reasons to restrain a resident applied to resident #84. Interview continued and confirmed it was well known to the nursing staff the resident transferred self from bed to w/c and into the bathroom unassisted. Interview revealed, "... (resident) is in our falling stars program, but (resident) hasn't had a fall since admission." Interview continued and verified the scoop mattress was used in an effort to prevent the resident from exiting the bed independently. Interview confirmed the scoop mattress had not been assessed as a restraint. Interview with LPN #4 on January 7, 2014, in the conference room, at 3:40 p.m., with concurrent review of the Care Directive provided each day for the certified nurse aides (CNAS), confirmed	F 221	**How will you identify other residents having the potential to be affected by the same deficient practice?** All residents who have concave mattresses will be assessed by DON/RN, and consents obtained for residents requiring the use of a concave mattress by 1/31/14. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nursing staff will be inserviced by the DON/RN on 1/31/14 that prior to utilizing a concave mattress an initial restraint assessment and consent must be obtained. Audits will be completed daily by the DON/RN by reviewing telephone orders for concave mattresses. DON/RN will review initial restraint assessments and consents for all concave mattresses. **How will the corrective action be monitored to ensure the deficient practice will not re-occur, i.e., what quality assurance program will be put into place?** DON/ADON/SKILLED MDS COORDINATOR will report findings of the audits to the interdisciplinary PI committee monthly for 2 months, or until 100% compliance is achieved.	2/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 of 14 out of a possible 15. Review of the plan of care dated October 23, 2013, revealed an approach under the Activities of Daily Living, "Capitalize on the resident's strengths and maximize independence." Review of the complete plan of care revealed the use of the scoop mattress was not included. Review of the facility's policy Physical Restraint Use revealed, "...facility...maintains an environment that fosters minimal use of restraints...The need...for restraint use is assessed on admission, at regularly scheduled interdisciplinary care plan conference reviews...A physician's order is required to apply any type of restraint." Interview with licensed practical nurse (LPN) #4 on January 7, 2014, in the conference room, at 3:10 p.m., with concurrent review of the Physical Restraint Use policy confirmed none of the five listed reasons to restrain a resident applied to resident #84. Interview continued and confirmed it was well known to the nursing staff the resident transferred self from bed to w/c and into the bathroom unassisted. Interview revealed, "... (resident) is in our falling stars program, but (resident) hasn't had a fall since admission." Interview continued and verified the scoop mattress was used in an effort to prevent the resident from exiting the bed independently. Interview confirmed the scoop mattress had not been assessed as a restraint. Interview with LPN #4 on January 7, 2014, in the conference room, at 3:40 p.m., with concurrent review of the Care Directive provided each day for the certified nurse aides (CNAS), confirmed	F 221	The Performance Improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of these audits. If deemed necessary by the committee, additional education may be provided, and/or the process evaluated/revised.	2/22/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 the Directive did not include providing assistance for transfers and toileting. Interview continued and confirmed the scoop mattress impeded the goal of the resident maintaining the highest ability to transfer to and from the bed. Interview continued and confirmed the scoop mattress had not been assessed as a restraint, ordered by the doctor, or consented to by the resident.			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instructions, review of facility policy and interview, the facility failed to ensure milk and nutritional supplements were disposed of prior to the expiration date in one of two unit pantries. The findings included: Observation of the refrigerator in the pantry on unit one on January 6, 2013, at 11:39 a.m., revealed:	F 371	**F371 FOOD PROCURE, STORE/PREPARE/SERVE--SANITARY** **What Corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 1/6/14 all milk products and nutritional supplements in the pantry refrigerator on unit one with expired dates were discarded by the unit one LPN charge nurse. **How will you identify other residents having the potential to be affected by the same deficient practice?** All unit pantry refrigerators were checked for expired milk products and nutritional supplements on 1/6/14 by the Certified Dietary Manager. No others were found.	2/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 3 1) Three half pints of skim milk with expiration date marked January 1, 2014 2) One four ounce chocolate shake dietary supplement thawed and undated. Medical record review of the facility's policy titled Nourishment Storage Areas (revised 01/01/2007) revealed the facility is to ensure the areas where nourishments and shakes are stored for the residents outside the Food and Nutrition Services department are maintained according to the local/state and federal regulations and facility guidelines. Continued review of guidelines revealed, "... Food is covered, labeled and dated appropriately. "...Food is rotated and/or discarded according to facility guidelines..." Medical record review of the manufacturer's instructions on the supplement box revealed, "... Thaw after refrigeration. Use in 14 days after thawing..." Interview on January 6, 2014, at 11:39 a.m. with License Practical Nurse #1 in the unit one pantry, confirmed the cartons of milk were available for resident use beyond their expiration date, and the nutritional supplement was thawed and undated.	F 371	**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not re-occur?** Dietary staff inserviced by Certified Dietary Manager (CDM)/Food Services Assistant Manager on 1/31/14 to check refrigerators for expired dates on milk products and nutritional supplements daily, discard them on the appropriate date, and document on log. CDM/Food Services Assistant Manager/Cook will check log daily to ensure dates are being checked on milk products and nutritional supplements and that these items are being discarded on the appropriate date. This check will be recorded on daily log. **How will the corrective action be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?** CDM/Assistant Food Services Manager/DON will report findings of the audits to the interdisciplinary PI committee monthly for 2 months or until 100% compliance is achieved. The Performance Improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation	2/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 3 1) Three half pints of skim milk with expiration date marked January 1, 2014 2) One four ounce chocolate shake dietary supplement thawed and undated. Medical record review of the facility's policy titled Nourishment Storage Areas (revised 01/01/2007) revealed the facility is to ensure the areas where nourishments and shakes are stored for the residents outside the Food and Nutrition Services department are maintained according to the local/state and federal regulations and facility guidelines. Continued review of guidelines revealed, "... Food is covered, labeled and dated appropriately. "...Food is rotated and/or discarded according to facility guidelines..." Medical record review of the manufacturer's instructions on the supplement box revealed, "... Thaw after refrigeration. Use in 14 days after thawing..." Interview on January 6, 2014, at 11:39 a.m. with License Practical Nurse #1 in the unit one pantry, confirmed the cartons of milk were available for resident use beyond their expiration date, and the nutritional supplement was thawed and undated.	F 371	Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of these audits. If deemed necessary by the committee, additional education may be provided, and/or the process evaluated/revised.	2/22/14
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	**F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** On 1/6/14, the Unit One LPN charge nurse	2/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 4 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and manufacturer's guidelines, the facility failed to ensure vaccinations were discarded before expiration date in one of two medication storage rooms. The findings included: Observation of the medication storage room refrigerator on unit one on January 6, 2013, at	F 431	discarded the undated Tuberculin Purified Protein Derivative (TB Skin test) and Influenza Vaccine. **How will the facility identify other residents with the potential to be affected by the deficiency?** On 1/6/14 all other medication storage refrigerators in facility were checked by LPN charge nurse for expired Tuberculin Purified Protein Derivative (TB Skin test) and Influenza Vaccine to ensure they were dated if open. No others were found to be undated. **What systemic change will be put into place to ensure the practice will not re-occur?** DON/SDC inserviced all licensed nursing personnel on or before 12/30/13 regarding guidelines for medication administration and med error reporting. DON/ADON/SKILLED MDS COORDINATORS/RN SUPERVISORS Nursing staff will be inserviced by DON/RN on 1/31/14 to date Tuberculin Purified Protein Derivative (TB Skin test) when opened and discard in 30 days and that Influenza vaccine is to be dated when opened and discarded in 28 days. Infection Control Nurse/RN Supervisor will audit the medication storage	2/22/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	01/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 5 11:25 a.m., revealed: 1)One Tuberculin Purified Protein Derivative (TB skin test) 5ml (milliliters) vial in refrigerator door opened and not dated. 2)One Influenza virus vaccine 5ml vial opened undated with three quarters of solution remaining. Review of facility's policy titled Medication Storage and Security in the Facility revealed, "...Medications and biological are stored safely, securely, and properly following manufacturer's recommendations..." Review of Tuberculin skin test manufacturer storage instructions revealed, "... Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." Review of the Influenza manufacturer's storage instructions revealed "...Once entered, a multi-dose vial, and any residual contents, should be discarded after 28 days..." Interview on unit one in medication storage room with License Practical Nurse #2 on January 6, 2014, at 11:25 a.m, confirmed theTB skin test vial was undated and opened. Continued interview confirmed the Influenza vaccine vial was opened and undated.	F 431	refrigerators daily for both expired or undated Tuberculin Purified Protein Derivative (TB Skin test), and Influenza Vaccine. **How will the facility monitor and ensure the deficiency is corrected and will not re-occur?** DON/ADON/SKILLED MDS COORDINATOR will report findings of the audits to the interdisciplinary PI committee for 60 days or until 100% compliance is achieved. The Performance Improvement committee includes the Executive Director, Director of Nursing, Medical Director, Consultant Pharmacist, Director of Rehabilitation Services, Director of Health Information, Director of Social Services, Director of Food Services, Director of Maintenance, Staff Development Coordinator, Skilled MDS Coordinator, Director of Environmental Services, and other Interdisciplinary team members. The PI committee will review the results of these audits. If deemed necessary by the committee, additional education may be provided, and/or the process evaluated/revised.	2/22/14